



**SOCIAL SERVICES BLOCK GRANT (SSBG)**  
**APPLICATION AND SERVICES REGISTRATION**

State Form 49452 (R2 / 9-09) / DHHS 0003

Family and Social Services Administration / Deaf and Hard of Hearing Services

Name of agency grantee

Contract number

Telephone number

( ) -

This State Agency is requesting disclosure of personal information that is necessary to accomplish the statutory purpose of the State Agency according to IC 12-13-5.2. Disclosure of information relating to racial / ethnic background, sex, marital status, or disability is strictly voluntary. Failure to provide any other information may prevent this application from being processed.

**SECTION A – SERVICES are hereby requested by or on behalf of:**

1. Last name of applicant	2. First Name	3. Middle Initial	4. County	5. County Code
6. Address (number and street, city, state, and ZIP code)			7. Telephone number	<input type="checkbox"/> V <input type="checkbox"/> VP <input type="checkbox"/> TTY
8. E-Mail address			9. Other contact	

10. SERVICE RECIPIENTS			11. DATE OF BIRTH (mm.dd.yy)	12. SEX Male/ Female	*13. RACIAL ETHNIC CODE	**14. MARITAL STATUS	***15. DISABILITY	****16. LIVING ARRANGEMENT	17. OTHER	*****18. GOALS
Last name	First Name	Middle Initial								

FAMILY SIZE		*RACIAL /ETHNIC CODE	**MARITAL STAUS	***DISABILITY	****LIVING ARRANGEMENT	*****GOAL CODE
19. Household		W = White	M=Married	D = Deaf	LI = Independently	I. Self Support
20. Children under 18		B = Black (not of Hispanic origin) H = Hispanic	D=Divorced S=Single	HH = Hard of Hearing DD = Developmental Disability	LP = with parents LG = in group home	II. Self-Sufficiency III. A. Prevent Remedy Abuse or Neglect
21. Total in family		I = Native American/Alaskan A= Asian – Pacific Islander M = Multiracial O= Other	SO= Significant Other W=Widow	DA = Dual Diagnosis O = Other	H = Homeless O = Other	B. Preserve, Rehabilitation and Reunite Families IV. Prevent Institutional Care V. Secure Institutional Care

Social Services will be provided without discrimination because of race, age, color, religion, sex, disability, national origin, or ancestry.

I hereby certify that the above information provided by me is correct and true to the best of knowledge; I understand that I may be required to verify these statements, and give my consent to the agency from which I am requesting Social Services to make any necessary contacts to verify and statements. I understand my rights and obligations, and have received a copy of them at the time of application I am a resident of Indiana.

22. Signature of parent and / or guardian (if child is under 18 years of age)	23. Date signed (month, day, year)
24. Signature of applicant	25. Date signed (month, day, year)